unreasonably high costs for providing center services. The Division of Medicaid has also adopted the health care staff productivity screening guideline as the basis for screening unreasonably high staffing levels or low productivity of staff.

E. Core Services Reimbursement Rates

The Division of Medicaid utilizes the prospective method for determining reimbursement rates for core services. Each individual health center's core services visit reimbursement rate for the prospective rate year will be for reimbursement of core services only. Other ambulatory services will be reimbursed based on the fee structures stated in other sections of the Medicaid State Plan. The prospective core service visit reimbursement rate will be based on the actual allowable costs of core services, as reported on the cost report and subjected to audit and/or desk review, divided by core service visits, plus a trend factor. See Chapter 3. The reasonableness limits applied to overhead and productivity on the cost report will likewise be applied when determining the reimbursement rate.

The rates are redetermined at least annually with payment to be effective August 1 for July services. Rates are in effect for the State of Mississippi fiscal year of July 1 - June 30, provided the

center has a valid provider agreement. Rates may also be changed during the fiscal year in accordance with other provisions described within the reimbursement plan.

Payment rates may be adjusted by the State pursuant to changes in Federal and/or State laws or regulations. All plan changes must be approved by the Health Care Financing Administration.

Interim rates - Interim rates from the effective date of the plan (July 1, 1990) and beyond the implementation date until a Medicaid rate can be set, will be the Medicare rate for Medicare core services and the Medicaid fee structures stated in other sections of the Medicaid State Plan for non-core services.

In no case may the reimbursement rate for services provided under this manual exceed an individual health center's customary charges to the general public for such services, except for those centers rendering such services on a sliding fee scale.

F. Cost Settlement

Reimbursement is subject to an annual reconciliation based upon the actual costs determined from the Medicaid cost report. The reconciliation will be prepared on the cost report Form 7. The

cost settlement will be as a result of the difference between the prospective reimbursement rate paired with the non-core service rates and the actual rates as determined on the cost report. The cost settlement may result in an amount due to or due from the provider.

Medicaid will notify the provider of the desk reviewed cost settlement in writing within ninety (90) days after the date the cost report is received. Amounts due to or from the provider will be settled within sixty (60) days following the issuance of the written settlement notice.

In the event that a subsequent audit of the provider's cost report results in noted differences which change the amount of the reimbursable cost by Medicaid, an additional cost settlement will be determined. Medicaid will notify the provider of the revised cost settlement in writing within ninety (90) days after the audit report date. Amounts due to or from the provider will be settled within sixty (60) days following the issuance of the written revised settlement notice.

G. Plan Amendments

This plan is subject to amendments pending experience obtained under the program and issuance of the Federal regulations.

1-2 AUDIT PROCEDURES

A. Appropriate audits, utilizing generally accepted auditing standards, will be conducted by the Division of Medicaid or contract auditors, to verify accuracy and reasonableness of information contained in all financial and statistical reports. Generally speaking, the Division of Medicaid will follow the audit standards specified by the American Institute of Certified Public Accountants (AICPA).

B. All participating Federally Qualified Health Centers will receive a field audit of their initial Medicaid cost report. A field audit will be performed on the final Medicaid cost report filed by a center which ceases to participate in the Medicaid program as a Federally Qualified Health Center.

C. Beginning January 1, 1994, the Division of Medicaid will insure that no less than one-third of all participating facilities are audited each year. At least 15% of these centers will be randomly selected and will receive a full scope audit and the remainder will be audited on the basis of exceptional profiles. Each provider will receive a full scope audit at least once every four years.

audit cost reports, financial records, and patient records to verify that:

(1) Only allowable costs have been included in computations

(2) Costs are properly allocated to cost centers and are reasonable

(3) Visits and full-time equivalents reported are actual and agree with center medical records.

E. The Division of Medicaid staff or contract auditors will review all financial and statistical reports within sixty (60) days following the due date to verify (to the extent possible) that all facilities have submitted reports properly and timely. When a facility has not complied, the auditors will conduct auditing as deemed appropriate.

F. Upon completion of each audit, the auditors will submit to the Division of Medicaid a report of audit which meets generally accepted auditing standards.

G. All audit reports will be retained by the Division of Medicaid for five (5) years following date of completion.

1-3 DESK REVIEW

The purpose of the desk review is to determine the allowability and reasonableness of FQHC provider costs in order to develop a prospective reimbursement rate as well as to determine cost settlement.

The desk audit will be directed toward the review and evaluation of cost reports prepared by providers in accordance with the State Plan. The procedures will consist of, but not be limited to, testing cost reports for completeness, accuracy, consistency and compliance with the program objectives. Limited adjustments may be made to rates reported by FQHC's based upon desk review findings. Other adjustments may be made to the reported per diem based on administrative decisions of the Director of the Division of Medicaid and audit findings based upon "on-site" field audits. Providers will be notified of all proposed adjustments and will be allowed 30 days from the date of such notice to furnish additional information to the desk auditor. The concurrence of the individual FQHC will be requested when adjustments are indicated; however, their non-concurrence will not prevent adjustments from being accomplished. Facilities will have the right of appeal in "non-concurrence" circumstances if they desire to do so, in accordance with provisions of Paragraph 1-7.

Desk review procedures consist of the following broad steps.

(1) Cost reports will be reviewed for completeness, accuracy, consistency and compliance with the State Plan. Necessary adjustments will be made. All findings and adjustments will be summarized in writing.

(2) The cost report will be compared with the prior year cost report and the prior year audit (if completed) for consistency. Necessary adjustments will be made and added to the written summary mentioned in (1) above, along with any other comments.

(3) All concurrence letters will be prepared and sent to the provider, showing all adjustments and changes.

(4) All findings, adjustments and comments will be reviewed with the desk audit supervisor.

1-4 PUBLIC NOTIFICATION

The Division of Medicaid will provide an opportunity for interested members of the public to review and comment on the rate methodology before it is implemented. This will be accomplished by publicizing in a newspaper with statewide circulation at least thirty (30) days prior to implementing the rate methodology or prior to making changes thereto. A period of thirty (30) days will be allowed for comment.

TN 90-08 DATE RECEIVED
SUPERSEDES DATE APPROVED 11/12/93
TN NEW DATE EFFECTIVE
AUG 21 1990

The Division of Medicaid will provide notification of the determined rate to the administrator of record for his/her health center.

1-5 GROUNDS FOR IMPOSITION OF SANCTIONS

Sanctions may be imposed by the Division of Medicaid against a provider for any one or more of the following reasons:

A. Failure to disclose or make available to the Division of Medicaid, or its authorized agent, records of services provided to Medicaid recipients and records of payment made therefrom.

B. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as adjudged by the Division of Medicaid or the MS Department of Health.

C. Breach of the terms of the Medicaid Provider Agreement or failure to comply with the terms of the provider certification as set out on the Medicaid claim form.

D. Documented practice of charging Medicaid recipients for services over and above that paid by the Division of Medicaid.

E. Failure to correct deficiencies in provider operations after receiving written notice of the deficiencies from

the Mississippi State Department of Health, Division of Health Facilities Licensure and Certification.

F. Failure to meet standards required by State or Federal law for participation.

G. Submission of a false or fraudulent application for provider status.

H. Failure to keep and maintain auditable records as prescribed by the Division of Medicaid.

I. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.

J. Violating a Medicaid recipient's absolute right of freedom of choice of a qualified participating provider of services under the Medicaid Program.

K. Failure to repay or make arrangements for the repayment of identified overpayments, or otherwise erroneous payments.

L. Presenting, or cause to be presented, for payment any false or fraudulent claims for services or merchandise.

M. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation to which the provider is legally entitled (including charges in excess of the fee schedule as prescribed by the Division of Medicaid or usual and customary charges as

allowed under the Division of Medicaid regulations).

N. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements.

O. Exclusion from Medicare because of fraudulent or abusive practices.

P. Conviction of a criminal offense relating to performance of a provider agreement with the State, or for the negligent practice resulting in death or injury to patients.

1-6 SANCTIONS

The following sanctions may be invoked against providers based on the grounds specified above:

A. Suspension, reduction, or withholding of payments to a provider;

B. Suspension of participation in the Medicaid Program; and/or

C. Disqualification from participation in the Medicaid Program.

Under no circumstances shall any financial loss caused by the imposition of any of the above sanctions be passed on to